A missed opportunity

Asylum seekers’ experiences of health screening for migrants in Sweden

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Abstract

**Aim:** The aim of this thesis is to, in Uppsala County, explore asylum seekers’ experiences of the health screening offered to newly arrived migrants in Sweden.

**Background:** Migrants in Sweden experienced more health problems than the general population. Asylum seekers had limited access to health care, but were entitled to a free health screening for migrants, including health information. Studies have shown that migrants and health care professionals alike identified problems regarding health screening. There was very little research on asylum seekers’ experiences of health screening.

**Methods:** Data was collected using semi-structured interviews, in English or with interpretation to Arabic, with eleven asylum seekers in Uppsala county. Data was analysed with qualitative content analysis.

**Findings:** During health screening, health professionals were considered nice and screening for infectious diseases was considered good, but other health needs were often overlooked. There was very limited health information communicated to the participants during health screening. Asylum seekers’ access to the health care system was perceived as limited, which resulted in avoiding seeking health care and relying on Swedish people to access health care.

**Conclusions:** Health screening seemed to be a missed opportunity to connect asylum seekers with the Swedish health care system. Insufficient health information, language barriers and several practical barriers contributed to asylum seekers’ limited access to health care. Improvements in how health screening is organised and conducted, increasing health literacy in the organisation, are needed to connect asylum seekers to the health care system.
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Glossary

**Migrant:** There are many different definitions of the term migrant and there is no internationally accepted definition (1). In this study, the International Organisation for Migration’s (IOM) definition is followed (2)\(^1\). This definition is wide, and encompasses many, very different, groups of migrants - for example asylum seekers, refugees, internally displaced persons (migrants who have not crossed an international border), undocumented migrants - and many reasons to migrate - forced or voluntary migration, labour migration, trafficking, etc (2). Different terms for migrants are used interchangeably across and within studies without clear definitions, according to a literature review published by the World Health Organization (WHO) (1). This has consequences for the access to health care for migrants as well as for the possibilities of comparing migrant health across EU member states (1).

**The Migration Agency:** The government authority responsible for considering applications for asylum and residence permit. The Migration Agency is also responsible for providing asylum seekers with housing and food during the asylum process (3).

**Scabies:** Common skin disease caused by an infestation of a parasite. Scabies is highly contagious during close contact, especially when living in crowded conditions. It is easily treated (4).

**Tuberculosis:** An infectious disease caused by the bacteria Mycobacterium tuberculosis. Globally very common in its latent form, which is non-symptomatic and not contagious. Spreads by airborne transmission, from individuals with active tuberculosis only. The incidence in Sweden and Europe is low, but higher in some migrants’ countries of origin (5).

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\(^1\) See Introduction
Introduction

Global migration
International migration has increased in the last 15 years and continues to do so (6). In 2015, there were 244 million international migrants worldwide. About one third of these, 76 million migrants, lived in Europe (6). Migrant is defined, by the International Organisation for Migration (IOM), as a person moving over an international border or within a state, regardless of the legal status, of whether the person has moved voluntary or not, of the reason for moving, or of the length of the stay (2). People migrate for many different reasons. Poverty, conflict and the hope for employment remains important factors for migration. Faster and cheaper ways of travelling makes it possible for more people to move across borders (6). In 2014, 19.5 million of the world’s migrants were refugees, of which more than 50 percent originated from three conflict-stricken countries; Syrian Arab Republic, Afghanistan and Somalia. The number of refugees has not been that high since World War II. The majority of these refugees migrate to neighbouring countries in Asia and Africa, but many also seek refuge in Europe (6).

This study focus on asylum seekers, which is defined by the IOM as a person “seeking safety from persecution or serious harm in a country other than his or her own” and is waiting for a decision on whether they will have the right to stay in this country, depending on if they will be granted asylum or not (2). In Sweden, the number of asylum seekers increased rapidly during the fall of 2015. Almost 163 000 migrants sought asylum during 2015, with the majority arriving after September, compared to 81 300 asylum-seekers in 2014. In November 2015, Sweden passed a new law relating to incoming asylum-seekers. The law prohibited entrance to the country without proper identification, and also limited the possibility to gain permanent residence permit or family reunions. This resulted in a decrease in the number of asylum-seekers the following year 2016, with only 29 000 migrants seeking asylum (7).

Migration and health
Due to increased global migration, finding solutions to improve and sustain health within the migrant group is, and will continue to be, an important public health issue. According to a briefing from the European Parliament on the public health dimension of the migration crisis (8) migrants are often in good health when they start their journey. Even though some infectious diseases are more common in some migrants’ countries of origin, than they are in the European countries they migrate to, it is important to clarify that there is an extremely low risk of an outbreak of infectious

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2 For more detail on the term migrant, see Glossary.
diseases as a result of migrants arriving to Europe (8). The risk is rather the opposite, that migrants risk being exposed to infectious diseases common in Europe (8). The Public Health Agency of Sweden supports this statement, as reported in a recent risk assessment of the spread of infectious diseases in Sweden (9).

Several factors in the country of origin, during the journey or in the host country can affect migrants’ health status negatively (9). Several literature reviews on migrant health in European countries, focusing on refugees, asylum seekers or undocumented migrants, show that these migrant groups experience more health problems regarding mental health (10, 11), oral health (12), perinatal outcomes (10) and general health status, especially regarding undocumented migrants (13, 14). All reviews conclude that the evidence is limited, that migrants seem to have problems in accessing care for legal and other reasons and that more research is needed (10-14). Having recently arrived in the host country, migrants’ health can be affected by living conditions in refugee camps or accommodation centres, limited access to health care services, and factors such as language and cultural norms which have been shown to be informal barriers to accessing health care. Therefore, it is important that national health systems are prepared to receive migrants and provide them with available, accessible and appropriate care that is sensitive to the needs of the different migrant groups (9).

Migrants in Sweden are generally less healthy than the rest of the population (15). The Public Health Report from 2009 shows that migrants - defined as people born outside of Sweden or with both parent born outside of Sweden - have lower levels of self-reported health than the remaining population (15). The main reason for this difference were socio-economic differences. Lower self-reported health was associated with lower economic standards, low status jobs and renting a home, as opposed to owning one’s home. Having experienced discrimination, as a migrant in Sweden, was also associated with lower health scores (15). Refugees and asylum seekers were considered more vulnerable than other migrants, since the risk of exposure to traumatic events before or during the refuge, the refuge itself and the stress and uncertainty of going through an asylum process increased the risk for post-migratory stress and mental health problems (9, 15, 16). This was especially evident during a prolonged asylum process, according to a report from the Red Cross from 2016 (16).

**Health care for migrants in Europe**

Regulations regarding migrants access to health care vary between the European countries (1, 10, 17). The European countries lack common strategies regarding health care for asylum seekers and
refugees, according to a literature review on the public health aspects of migrant health (10). According to the Migrant Integration Policy Index (17) and a literature review published by WHO (10), some European countries grant all residents, migrants as well as citizens, access to practically the same health care services. There are also countries granting no access to the health care system at all, except perhaps emergency care, to legal migrants, asylum seekers and undocumented migrants (1, 17). These differences seem to remain despite the European Union’s attempt to harmonise the services offered (18). The European Parliament encourages the European member states to improve the health care granted to vulnerable groups, including migrants and undocumented migrants (8). According to a study from 2011, there was consensus among country experts in migration and health from sixteen EU member states on what constitutes good practice in health care for migrants, even though the countries differed in immigration policies and access to health care for migrants. The country experts agreed on, among other factors, that equal, accessible high quality health care, culturally sensitive health care services and patient-health care provider communication were important factors for good practice (18). The previously mentioned review (10) issued similar recommendations, and highlighted that legal restrictions, especially for pregnant women and for children, need to be removed to increase access. The European Centre for Disease Prevention and Control (ECDC) issued an advisory document for the public health needs of migrants in Europe in September 2015. The report highlighted the need for health assessments for migrants soon after arrival, access to free health care, adequate living conditions, and health information and education tailored to the migrants in terms of language and cultural understandings (19). Granting migrants regular health care also has financial benefits, as seen in a recent German study, which showed that granting asylum seekers and undocumented migrants regular access to care is more cost effective than restricting access to care, which often leads to delayed care and, in the end, higher treatment costs (20). In spite of all the positive evidence relating to the gain in health levels and economy when equal access to health care is provided, to migrants as well as nationals, and the advice of country experts as well as ECDC and European Parliament, legal and practical access to health care still varies between countries in Europe.

Health care for migrants in Sweden
The Swedish health care system is mainly tax-financed through counties and municipalities. Almost all health care is subsidised for Swedish citizens. There is generally a small fee charged for adults, while almost all health care is free of charge for children. This also applies to migrants with residence permit. Asylum seekers and undocumented migrants have the right to “health care that can not be postponed”, as well as maternal health care, abortion related health care, family planning and health screening for migrants (21, 22). The term “health care that can not be postponed” has
been criticised in a report from the National Board of Health and Welfare from 2014 (23). The decision on whether health care “can be postponed” or not is up to the individual health professional to decide, which poses a risk for patient safety. Additionally, this does not comply with the ethical principles which Swedish health care is based upon (23). Regarding other migrants, such as migrants from other EU member states, the access to subsidised health care depends on insurance.

Previous studies show challenges in health care provided to migrants as well as in the communication between the health care system and the migrant group (24-27). In a Swedish interview study, care-givers identified challenges in working with migrant patients; the influence of sociocultural differences on the health care encounter, the difficulty for migrants to navigate in the health care system and the language barrier limiting care and information (24). In another Swedish study, interpreters were considered both a possibility and a problem by migrants, showing the complexity of using interpreters in health care (25). In a study from northern Sweden, fear of stigmatisation and deportation made migrants living with HIV or uncertain of their HIV status reluctant to seek health care, highlighting a lack of trust (26). To improve health care for asylum seekers and newly arrived migrants, the National Board of Health and Welfare suggested, in a report, several measures to be taken. These included national coordination of information to asylum seekers, better access to transportation between accommodation and health care and increasing access to interpreter or other language support systems (27), which partly adheres to the mentioned recommendation from experts (18, 19). In other terms, previous research indicate that there are barriers for migrants to access health care, which are yet to be reduced.

Health screening for migrants
Health screening for newly arrived migrants is an opportunity to identify health needs in the individual and provide the appropriate referral within the health care system, if needed (19, 28, 29). According to ECDC, health assessment soon after arrival to Europe is an important public health aspect for the migrant population (19). Just as access to health care varies between European countries, so do the regulation and practice surrounding health screening for migrants. In a comparative study of the European Union member states from 2005, all countries except Greece offered health screening on arrival for asylum-seekers. However, the routines and content of the health screening varied, as well as whether the screening was compulsory or voluntary for the migrants (28). A more recent study, focusing on screening for infectious diseases, also showed that in 2014 the practices of screening varied among European countries, regarding screening for infectious diseases. Screening was considered useful by the experts interviewed in the study, who also welcomed EU level guidelines for screening (29). Health screening is sometimes referred to as
Health assessment, medical screening or health examination. In this study, the term health screening will be used, as in most other Swedish studies.

**Health screening for migrants in Sweden**

In Sweden, health screening is voluntary (30). The aim is to identify, treat and prevent health problems and infectious diseases, as well as provide the newly arrived migrant with information about their legal access to health care and practical information about the health care system. According to Swedish law, health screening must to be offered to all asylum-seekers, to quota refugees through UNCHR and to migrants who has been granted a residence permit to join a family member who has been granted asylum in Sweden. These are invited by mail. Health screening should also be offered to undocumented migrants when they seek health care (30, 31).

Depending on county, health screenings are either conducted by one central health care centre or by several different health care centres, which are financially compensated by the Migration Agency. Additionally, some Swedish counties also offer health screening to other migrant groups, such as migrant workers. The Migration Agency does not have access to the results of the health screening or the medical records, nor does the result affect the migration process (30).

Health screenings are generally conducted by nurses, although in some cases by doctors (31, 32). If needed, an interpreter is used. Guidelines state that the patient should initially receive information about the law of professional confidentiality within health care, and that this also applies to the Migration Agency and other government institutions (31, 32). The same guidelines state that health screening should consist of a conversation to assess general health status, risk for infectious diseases and previous vaccinations, screening for infectious disease by blood tests, a physical examination, if needed, and information about the Swedish health care and dental care system. The risk for infectious diseases is assessed with regards to the epidemiological situation in the countries or regions the patient lived in or travelled through, as well as with regards to previous exposure to infectious diseases (for example tuberculosis) or hospitalisation (screening for multi-resistant bacteria). The patient should be given the opportunity to talk about any health problem he or she identifies as important, and about migration-related health problems, traumatic experiences, sexual health and mental health (31, 32). Information about the regulations regarding access to health care, dental care and related services, and how that applies to the individual patient, should be provided. It should also include information about how Swedish health care is organised and the different

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3 See Glossary.
4 See Glossary
5 See Glossary
6 See Glossary
roles of health professionals, how and where to seek health care as well as contact details to their health care centre and dentist (31, 32). As this migrant group is very diverse, providing appropriate information requires different kinds of communication for different individuals depending on previous knowledge and education (9, 20, 30). Finally the nurse can, if needed, for example considering contact with a midwife for a pregnant woman, make an appointment or provide patients with enough information to be able to make the appointment themselves (31, 32).

In 2013, fewer than 50 % of asylum seekers in Sweden attended health screening, a number that has been almost consistent for several years (30). In 2015, this number was only about 39 %. Although, this number is assumed to be lower due to the increase of people seeking asylum in late 2015, according to a report from the Swedish Association of Local Authorities and Regions. The increase of asylum seekers also led to drastically increased waiting times, where some had to wait up to one year for health screening (33). The low attendance is thought to be a result of the information concerning the health screening not being communicated in an appropriate way, for example not in a language the migrant understands or with insufficient or confusing information. Other reasons could be that the letter with the notice did not reach the patient, that the cost of travelling to the health care centre was too high, or fear that the results of the health screening might affect the possibilities of staying in Sweden (30). According to the mentioned report (33), centralised health care for asylum seekers and refugees, mobile teams working with health screening and employees working specifically with communicating health related information to migrants, in their primary language, seems to be effective ways of improving the attendance to health screening (33).

A few Swedish studies have shown both the nurses conducting health screenings (34, 35) and the migrant patients (36-40) experience challenges in health screening. This is also mentioned as a possible reason for the low participation in health screening (29). Fear of collaboration with the Migration Agency⁷ that might affect the asylum or immigration process, was seen in several studies (34, 35, 37). In one study, migrants had to wait a long time for health screening and experienced problems with communication, both with and without interpreters (35). In an interview study, Eritrean migrants experienced communication problems, especially regarding receiving limited information about Swedish health care as well as about the blood tests taken (37), with similar findings in quantitative studies (38, 39). Many had not received any advice or treatment for their health problems. Being discontent with that health screening focused more on infectious diseases, than what participants experienced to be their main health problem, was a common experience (35, 37).

⁷ See Glossary
The nurses added that they and the patients often had different expectations on the health screening (34) and that health care advice was not always accepted by migrants, who expected other treatments (35). A study using focus group discussions with health care professionals and staff from the Migration Agency\(^8\) identified organisational issues in the work with health screenings, which led to limited information about the health screening reaching migrants, and need for improvements in both organisation and competence (35). Despite the challenges surrounding health screening, both health professionals and migrants in these studies generally considered health screening an opportunity to identify health needs and provide migrants with much needed information on their rights and on the Swedish health care system.

In the county where this study was performed, health screening was the only occasion that asylum seekers received information about the regulations surrounding health care, except for sporadic initiatives by various organisations. A Swedish study evaluating an intervention with health information, very similar to the information ideally provided during health screening, showed positive results. The asylum seekers had experienced a need for information and felt relieved after listening to it (40).

**Rationale of the study**

There is limited research on health care and health screening for asylum seekers. The research that has been conducted show challenges in health care and health screening for migrants. Most previous studies focus on the views and experiences of health professional or experts, rather than on the receivers of the health care and health screening. In this study, asylum seekers’ experiences are the focus of interest. Their unique perspectives as patients during health screening, and their unique experiences as individuals going through the asylum process and living in Sweden as asylum seekers, means that they can provide valuable information on the practice of health screening.

In 2016 the author of this study worked as a nurse at the health care centre in Uppsala, Sweden, where health screenings for migrants in Uppsala county were conducted. The author identified a need for the patients’ voices to be heard when evaluating, improving and organising the work at the health care centre, as well as when developing guidelines at a national level. The lack of research on asylum seekers’ experiences of health screening made it difficult to organise health screening according to this group’s unique needs. With more research, migrant patients can be included as important resources, in improving how health screening is conducted and to ensure that health care

\(^{8}\) See Glossary
centres are able to meet their needs. The findings of this study can be used to increase the understanding about how the asylum seekers experience health screening, among health professionals and policy makers, and to improve health screening for asylum seekers from an organisational perspective.

**Overall aim**

The overall aim of this thesis was to, in Uppsala County, explore asylum seekers’ experiences of the health screening offered to newly arrived migrants in Sweden.

**Research question**

How did asylum seekers in Uppsala county, Sweden, experience health screening for newly arrived migrants?

**Specific objectives**

I. To explore asylum seekers’ expectations on health screening, and whether these expectation were met.

II. To explore how asylum seekers experienced that their health needs were treated during health screening.

III. To explore how asylum seekers experienced the information received during health screening.

**Health literate organisations**

The theoretical framework for this study is the theory of health literacy, with focus on health literate organisations. The framework has been applied to the findings, in order to guide the researcher to an understanding of how the health care organisation has affected the participants’ experiences of the health screening as well as to identify improvements in the health care system’s organisation of health screenings.

In this study, health literacy is defined by one of the most commonly used and widely accepted definitions (cited below), developed by the European Health Literacy Consortium in 2012 (41). In this definition, health literacy is a broad concept which encompasses people’s entire ability to control aspects which determine their own health (41). Limited health literacy has been seen to lead to poorer health and to be associated with un-healthier choices, more hospitalisation, riskier behaviour and less self-management in health. In Europe, migrants often have lower health literacy levels than the remaining population (41).
“Health literacy is linked to literacy and entails people’s knowledge, motivation and competences to access, understand, appraise and apply health information in order to make judgements and take decisions in every-day life concerning health care, disease prevention and health promotion to maintain or improve quality of life during the life course” (41, p. 4).

Maintaining a healthy life in today’s society means navigating in a complex health system and assessing constant health information from different sources (41). Health literacy is both related to the skills and abilities of the individual and the demands and complexity of the health system surrounding the individual. As the demands or complexity of a setting increases, a person’s health literacy can decrease, if the skills and abilities does not increase to the same extent. This means that a person might have high health literacy in one setting, but in another setting where the demands are different, the person’s skills and abilities are not sufficient and the person’s health literacy becomes insufficient. For migrants, this is a particularly important aspects, as many do not speak the language nor are familiar with the health system in the host country, which means a sudden and dramatic increase in both demands and complexity in the health system compared to in the country of origin. To increase health literacy both on an individual level and on a population level, the skills and abilities among individuals need to be increased, and the demands and complexity of the health system need to be decreased, at the same time (41).

Health literate organisations is a term for organisations which adjust these demands for the patients, decrease the complexity and make it easier for individuals to find, understand and get access to information and health services (42-44). Until recently, the scientific literature has mostly focused on the communication aspect and skills of health care professionals to provide care to individuals with low health literacy, according to a literature review of health literate health care organisations from 2016 (43). A discussion paper, published by the National Academy of Sciences in the United States of America, attempts to shift the focus to the management of organisations instead. The authors suggest 10 attributes (Table 1) of health care organisations that “make it easier for people to navigate, understand and use information and services to take care of their health” (42), or in other words, increase the health literacy of the health care organisations. The attributes are developed based on the American health care system, but they are just as relevant for the Swedish system.
Table 1. Ten attributes of a health literate health care organisation (45).

1. Has leadership that makes health literacy integral to its mission, structure, and operations.
2. Integrates health literacy into planning, evaluation measures, patient safety, and quality improvement.
3. Prepares the workforce to be health literate and monitors progress.
4. Includes populations served in the design, implementation, and evaluation of health information and services.
5. Meets the needs of populations with a range of health literacy skills while avoiding stigmatization.
6. Uses health literacy strategies in interpersonal communications and confirms understanding at all points of contact.
7. Provides easy access to health information and services and navigation assistance.
8. Designs and distributes print, audiovisual, and social media content that is easy to understand and act on.
9. Addresses health literacy in high-risk situations, including care transitions and communications about medicines.
10. Communicates clearly what health plans cover and what individuals will have to pay for services.

In this study, attributes 4-8 and 10 (Table 1) will be used for discussing the findings from an organisational perspective. These attributes were chosen based on that they are directed outwards, towards the patients, as compared to directed to internal factors within the organisation. They are considered more relevant for this study, considering that this study focuses on the patients’ perspective and experiences.

Methods

Research design
The study was carried out using a qualitative research design. Qualitative research explores groups’ or individuals’ experiences or understandings of a phenomenon. It is a useful approach when there is limited previous research on the topic. The topic of this study was largely unexplored, the focus of interest was the participants’ own experiences and the researcher wanted to reflect the voices of the participants, which made a qualitative approach suitable (46).
Research setting
The study was carried out in Uppsala county, located in Sweden, with a population of 360,000 inhabitants. The health screenings in the county were organised by and performed at a health care centre located in the regional capital Uppsala city, the fourth largest city in Sweden. The two asylum accommodation centres mentioned in the study were located outside Uppsala city.

At the time of the study, the researcher worked as a nurse at the health care centre where health screenings were performed. Recruitment and interviews were conducted as a part of that employment. The rest of the study was conducted as a part of a master’s program at the university. The interpreters used during the interview were financed by the health care centre.

The political context was important to this study. Increasing global migration and the fact that more people were seeking refuge in Europe (6), has increased the interest for migrants’ health, within the health care system as well as in public debate. Sweden had also experienced an increase in people seeking asylum, mainly in the fall of 2015 (7). Health screening for migrants had been conducted for years, but the change in the political situation had resulted in changes in the health care system’s routines for health screenings. At the health care centre in Uppsala, where health screenings were conducted, several new nurses had been hired to increase the number of health screenings performed. In addition, new routines were implemented, for example a mobile team which conducted health screening at asylum accommodation centres. It is important to recognise this context for the study, since both recent changes and the political situation might have affected the results.

Participants
The eleven participants in the study were asylum seekers residing in Uppsala county, who had attended the health screening in Uppsala county in the last 18 months and were willing to participate in the study. Some participants had visited the health care centre for health screening, and for some, health screening had been conducted at the asylum accommodation centre, where they lived. Only adults over 18 years old were included in the study. All had lived in Sweden for less than 2 years. Both men and women were included and they originated from different countries.

The first exclusion criterion was if the researcher herself had conducted the participant’s health screening, since that might prohibit the participant from speaking freely about negative experiences.
The second exclusion criterion was if the participant spoke a language which no suitable interpreter could be arranged for, as the researcher then could not guarantee appropriate communication.

Only participants who had gone through health screening were recruited to the study. This means that experiences among asylum seekers who, for any reason, did not attend health screening, were not part of this study. These experiences would have been essential to identify possible fears, understandings or opinions explaining the low attendance at health screening among asylum seekers. Therefore, this study does not attempt to explain this low attendance.

**Recruitment of participants**
Diversity sampling was applied when recruiting participants. Asylum seekers is a diverse group. By recruiting participants of different genders, originating from different parts of the world, of different ages and with different forms of accommodation in Sweden, the researcher aimed to include different perspectives and experiences of the health screening (46).

The participants were recruited through visits to two of the largest asylum accommodation centres around Uppsala and to a language school for asylum-seekers and undocumented migrants, as well as through snowballing, as some participants referred the researcher to other possible participants. The participants at the asylum accommodation centres were approached during personal visits. The researcher was assisted, on different occasions, by an Arabic-speaking colleague from the health care centre, an interpreter and a staff member from an asylum accommodations centre who was fluent in several languages, most importantly in Dari. To decrease the risk of individuals feeling compelled to participate, information about the study was given to small groups of people instead of directly to individuals. Thereafter, individuals could approach the researcher with questions or expressions of interest in participating. The participants at the language school had more knowledge of Swedish and received information in Swedish and English during a class, from the researcher. During the recruitment visits, information about the researcher, about the aim of the study and about how the interviews were to be conducted was provided. The participants were informed that all participation was voluntary and that their identities would be kept confidential. They were informed that the results would be presented at the university and at the health care centre. Written information in Swedish and English (*Annex 1*), with contact details for the researcher, were handed out to those interested in participating.

When a participant had agreed to participate in the study, a date and a place for the interview was booked, with consideration to what was most convenient for and preferred by the participant. In
some cases the author contacted the participants afterwards, by phone or email, with a suggestion for a date. Two or three interviews at an asylum accommodation centre were conducted later on the same day as the participant was recruited.

There were no financial reimbursements offered to participate in the study. To avoid travelling costs for the participants, the interviews were arranged according to the participant’s schedule. Interviews were only conducted at the health care centre if the participant chose that arrangement and did not have to travel far to get there. In most cases, the researcher came to the participant’s home at the asylum accommodation centre (46).

Data collection
Data was collected through semi-structured interviews. A health care situation can be experienced as quite personal and sometimes intimate. It was considered important to use a data collection method which allowed the experience of the health screening to be just as personal as the participant experienced it (46). Semi-structured interviews allows the participants to elaborate on their own, personal experiences, while the researcher can ensure that certain pre-decided topics are covered in the interview. This combination is not possible in either in-depth interviews nor focus group discussion, which led the researcher to chose semi-structured interviews (46).

The eleven interviews were conducted between October 2016 and January 2017. The location was chosen depending on what suited the participant best (46). Most participants preferred coming to the health care centre or to an office room at the asylum accommodation centre, where a calm and private environment could be offered. Some participants preferred doing the interview in their own rooms at the asylum accommodation centre, even if this offered less privacy since friends and family members entered the room and sometimes joined the conversation. One participant explained that she felt safer in her own room, since she did not want the staff members at the asylum accommodation centre to hear.

Before the interview started, all participants received written information, in English or Swedish (Annex 1), and verbal information in their preferred language. This was essential to ensure informed consent, since there were not interpreters present when all participants were recruited (46). The information included the aim of the study, the plans for the results, who the researcher was and what kind of questions would be asked, as well as that participation in the study meant agreeing to an audio recorded interview. The participant received information about that their identity would be kept confidential, that participation was completely voluntary and that they could withdraw from the study at any time during the interview or afterwards, without any consequences for their health.
The participant had the opportunity to ask questions. Thereafter, the researcher asked if the participant was comfortable signing a consent form (*Annex 1*). All participants chose to sign the consent form, except for one, who was included in the study after giving her verbal consent instead. Since the consent forms were only available in English and Swedish, the opportunity to have the whole consent form read to them in their preferred language was given to all participants during interviews with interpreter.

The length of the interviews ranged between 16 and 43 minutes. Three participants chose English as the interview language. The rest were performed in Swedish, with an interpreter to the language the participant preferred. The researcher purposively selected interpreters who had previous experience of working with health screenings and were known at the health care centre to have a good reputation among patients. The interpreters were informed about the study before the interviews.

The interviews were guided by an interview guide (*Annex 2*), constructed by the researcher. Initially, the researcher asked the participant to share their experience of the health screening. Thereafter, the researcher used probes and short summaries to encourage the participant to elaborate on their experience and to clarify details. Short summaries was also used to feedback what the participant said during the interview, to ensure that the researcher had understood correctly. This was considered important since interpreters were used, where clarifications are more often needed. Although, in the interviews conducted in English, it was equally important since neither the researcher nor the participant spoke their first language. The researcher ensured that all topics in the interview guide (*Annex 2*) had been brought up during the interview. The interviews were ended when the participant did not have anything more to add, no new ideas were generated and the researcher did not have any further questions.

The interviews were audio recorded, with the participant’s consent and the consent of anyone else entering the room during the recording. The recordings were kept in a computer locked with a password that no one except the researcher had access to. During the interview, the researcher took brief notes on ideas or reflections made. After each interview, the researcher took a moment to reflect on the interview and took notes of any reflections, ideas or patterns that came up.

The interviews were transcribed verbatim by the researcher. Only the translated parts, in English or Swedish, were transcribed. All names mentioned in the interviews, except the researcher’s name, were removed during transcribing. The transcripts were kept in a computer locked with a password, to which no one except the researcher had access. The interpretation between Arabic and Swedish
was validated and approved by a person with no connection to the study, who had a health care education and was fluent in Arabic and Swedish. A sample of the interviews, interpreted by the main interpreter and where no names were mentioned, were listened to and validated by this person.

**Analysis**

The data was analysed using qualitative content analysis. Content analysis is often used to produce an overview of people’s experiences on a topic or an event (46, 47). In this study, content analysis was used to identify the manifest content of the interviews, to stay as close to the participants’ voices as possible and report on their experiences and suggestions (47). This was considered useful since the manifest content provided an understanding that could be used as base for suggesting practical improvements. The analysis was discussed with the supervisors, with the student feedback group and with health professionals with experience from conducting health screening throughout the process.

Qualitative content analysis is a process involving several steps (46, 47). In the first step the researcher familiarised herself with the data, both through transcribing the interviews and listening to them repeatedly, as well as going through notes and comparing them to the recorded interviews. The researcher also made notes about recurring topics and similarities in the data (47).

The second step was identifying the meaning units in the data. Meaning units is a piece of the text, often in the length of a sentence or a few sentences, which is related to the research question. The meaning units were condensed to shorten the text but preserve the content, and then labelled with a code which in one or a few words described what the meaning unit was about (47). All codes were kept in its original language, which means that some were in Swedish and some in English (47).

In the third step, the codes were grouped into categories by cutting the transcripts into segments and sorting under categories. At the same time, sub-categories were identified for each category. The categories were mostly identified using an inductive approach, meaning that the categories are not pre-defined but were identified from the data (47). Although, the second category was identified using a deductive approach, based on one of the research questions. This process had several steps, as categories were repeatedly created, reconsidered by going back to the interviews and then replaced with new categories, until a representative picture of the participants experiences had been painted. The categories represent the manifest content in the data, which means that little interpretation was involved and the researcher aimed to keep the categories close to the participants’ statements (47). From creating the categories and onwards, all material was translated to English.
Ethical considerations

The study did not have any ethical permit, but, according to university guidelines, since the researcher conducted the study as her master thesis an ethical permit was not necessary. The ethical principles for medical research involving human subjects as described in the World Medical Association’s Declaration of Helsinki (48) has been followed when designing and conducting the study. Special consideration was given to the section on vulnerable groups. Apart from that, the International Council of Nurses’ (ICN) Code of Ethics for Nurses (49) has been considered and followed throughout the study. The four ethical principles of Beauchamp and Childress (50) - autonomy, beneficence, non-maleficence and justice - was also considered. Special emphasis was placed on justice. Asylum seekers are a vulnerable group in Swedish society and their own voices are rarely heard in the public debate on migration. It can be argued that reflecting the voices of under-represented groups is a researcher’s duty (46). Due to the uneven power balance between the researcher and the participants as a group, measures were taken to minimise the risk that the participants felt compelled to participate (48). In this case, seeing asylum seekers as a patient group with several obstacles to receiving the same access to and quality of health care as the general population, it is even more important to consider the patients’ perspective (49). Justice, in this case, means contributing to achieving equal access to health care for all.

Several measures have been taken to ensure that participants took part in the study voluntarily. Among those measures were, as mentioned before, the researcher generally providing information to groups rather than individuals and informing repeatedly that all participation is voluntary. Several people approached declined participation in the study. Even so, it can never be ruled out that participants felt compelled to participate in the study. Of special concern is the fact that the researcher worked at a health care centre. Considering the perceptions that health screenings affect the asylum process (34, 36, 37), there was a risk that some participants thought that declining or agreeing to participate might affect their asylum process or future health care.

Gatekeepers are important for access to participants but can affect both participants’ choices and who the researchers has access to (46). Gatekeepers have to some extent been used in recruiting participants, but can be expected to have a limited impact on who participated in the study. The managers of the language school and the asylum accommodation centres were important for the researcher’s access to the participants. But they merely allowed the researcher to access the centre

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9 See Recruitment of participants and Data collection
and the school, and did not put the researcher in contact with individual participants. The health care professional and the staff member, who helped at the recruitment visits, might have had the social effect whereby participants felt compelled to participate. But since the interview was conducted on a later occasion, the participants had several opportunities to decline participation.

That the researcher worked as a nurse at the health care centre where health screenings were conducted also means that participants might not be willing to share negative experiences of the health screening. To reassure participants that all their experiences were equally valid and important to the study, the researcher explained that the health screening needed to be improved and asked for the participants help in improving them. During the interviews, the researcher aimed to encourage the participant to elaborate equally on positive and negative experiences. In some interviews, when the participant only expressed positive experiences, the researcher focused more on suggestions for improvements instead of negative experiences.

Using interpreters in an interview study means that the interpreter has a very important role (46). The researcher had previously worked with and trusted the interpreters in this study, who received a verbal introduction to the study from the researcher, before the interviews. One interpreter, interpreting several interviews, provided insightful suggestions for clarifications based on knowledge of cultural understandings. Interpretation was financed by the health care centre where the researcher was employed, but the interpreters were employed by a separate interpretation agency. Interpretation in health care is guided by rules of professional confidentiality and impartial interpretation, and the interpreter is supposed to translate every spoken word. There is no reason to believe that any of the interpreters in this study would not adhere to these rules.

After the interview, several of the participants asked for help with health problems. Some of the health problems were recent and some had been present at the health screening, but had not been treated. In all cases, the researcher either gave the participant medical advice or arranged for a health care contact. Since the researcher was a nurse and a representative for the health care centre as well as a researcher, it was an important ethical stance to help the participants with their health problems. As the researcher had previously visited, as a nurse, both the asylum accommodation centres and the language school, individuals other than the participants also approached the researcher seeking advice for health problems. They also received helped with either medical advice or a health care contact, even if it took time and resources that could have been used for the study. This can be considered in line with both the Helsinki Declaration (48) and the ICN Code of Ethics (49), in that the well-being of a person is prioritised over the interest of research.
Reflexivity

The researcher is a Registered Nurse. Therefore, one underlying assumption for this study is that health care and nurses’ role within the health care system can affect a patients’ health outcomes in a positive way. Another assumption is that the nurse-patient relationship and interaction is important for the outcome of the health care appointment and treatment. An important part of nursing is the idea that a patient is competent and an expert on their own situation, even if being a patient can mean increased vulnerability (49). Therefore, it is essential that patients’ voices, in this case asylum seekers, should be heard in the health care system. The researcher’s background in the health care system has led to taking certain aspects for granted, like the difference between a health screening and other health care appointments or nurses’ and physicians’ professional roles, which the participants did not perceive the same way. For this reason, the researcher tried to keep an open mind throughout the study and consciously questioned these assumptions, asked for clarifications and discussed the findings with people outside health care for new perspectives.

Since the researcher has been working with health screening for migrants there is an obvious risk that another underlying assumption is that health screenings are a good thing, that they are useful and important when done in an appropriate way. To avoid missing a result that would indicate that health screenings are inappropriate, not useful or even harmful, the researcher has attempted to stay as open as possible to the experiences of the participants and value all their experiences equal.

The researcher is also a student at the master program in international health and an active member of an human rights organisation that promotes equal access to health care for all. That access to health care and the best possible health is a human right (51) is another important assumption of this study. This also includes the acknowledgement that people do not today, in a global as well as a Swedish perspective, have equal access to health or health care, and that this inequality has a negative effect on public health. This has most likely influenced the choice of researching this topic, but it is less likely to have affected the outcomes of the study.

The researcher was born in Sweden of Swedish parents and have no experience of migration. This, together with insight into the Swedish health care both from working in it and from education, puts the researcher in a position of power compared to the participants, who are new to the Swedish context and are not familiar with the health care system to the same extent. To minimise the effect this had on the study the researcher contacted the participants with interpreters to their language, took measures to avoid participants feeling compelled to participate and attempted to encourage
positive and negative experiences equally during the interviews, as previously mentioned\(^\text{10}\). Although, it might also have had a positive effect on the participants’ willingness to share their experiences. Some participants expressed appreciation that the researcher were interested in their opinions and hoped that the researcher would be able to increase asylum seekers’ access to health services.

**Findings**

The participants were between the ages of 26 and 44 years. Six participants were women and five were men. They originated from different countries, but the majority of the participants came from Syria (6 participants), of which one was Palestinian but had lived in Syria. Two participants were Palestinian, one came from Bangladesh and one from Afghanistan. For one participant, the country of origin is unknown. The majority of the participants lived in asylum accommodations centres, but three participants had other, private, arrangements for their accommodation. For an overview of the participants, see the table in *Annex 3*.

*Table 2. The categories and the sub-categories.*

<table>
<thead>
<tr>
<th>Categories</th>
<th>Sub-categories</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caring health professionals but unmet health needs during health screening</td>
<td>Health professionals were nice and caring</td>
</tr>
<tr>
<td></td>
<td>Health screening was considered important for identifying infectious diseases</td>
</tr>
<tr>
<td></td>
<td>Unmet health needs during health screening</td>
</tr>
<tr>
<td></td>
<td>Different expectations on a health screening</td>
</tr>
<tr>
<td>The need for more information</td>
<td>(none)</td>
</tr>
<tr>
<td>Problems related to the accessibility of the health care system despite having attended health screening</td>
<td>The health care system is difficult to access</td>
</tr>
<tr>
<td></td>
<td>Relying on others to access health care</td>
</tr>
<tr>
<td></td>
<td>Avoiding to seek health care</td>
</tr>
</tbody>
</table>

Three categories, each with between two and four sub-categories (*Table 2*), were identified. These reflect the manifest content in the data, meaning that they describe the participants’ expressed

\(^{10}\) See Data collection
experiences of the health screening with very little interpretation from the researcher. Quotes were included to bring the reader closer to the participants and were chosen for being representative of the data.

### Caring health professionals but unmet health needs during health screening

When asked about their experiences of the health screening, the initial response from most participants was that health screening was good and that the health professionals were nice. But, most participants also highlighted experiences of the health screening that was less positive. The most common negative experience were disappointment due to unmet health needs and expecting a health screening to include other medical examinations.

### Health professionals were nice and caring

All participants but one agreed that the health professionals had been nice and caring. One participant, who had worried about the health screening before the appointment, said that after being met with kindness and information about professional confidentiality from the nurse, he recommended his friends to go to the health screening.

> Some people are worried because there are many questions and because they are asylum seekers, but the nurse tells you that professional confidentiality applies to the health screening and that this has nothing to do with the Migration Agency, so then you feel relaxed and can talk about your problems. P5. Man, 28 years, Palestine, interview in Arabic.

Although, this did not always mean that the participants felt that the health screening has given any positive results on their health. The health care professionals were experienced as nice, even when the participants were not satisfied with the health care. The interaction and the care received were considered separately. Two participants mentioned that they specifically appreciated being asked about how they experiences their health as a whole, meaning that they nurse they met had a holistic view on health.

> I think that asking about everything and wanting to know everything about the person is a good balance. I am more used to, in our countries, you only talk about physical health, you don't consider the mental problems. There are private doctors for each specific thing but they don't look at the whole person. I though it was nice (...) it made you curious and you dared to ask the questions you had. P8. Man, 37 years, Syria, interview in Arabic.
Health screening was considered important for identifying infectious diseases
Many of the participants had travelled to Sweden over the Mediterranean Sea and through Europe, and had lived under deprived circumstances during that time. Several of these participants were concerned that they would have contracted any infectious diseases on the way and were relieved to be tested for infectious diseases during health screening.

*I think it is very good, because it is a relief when you find out that you have not been infected with any disease.* P9. Man, 41 years, Syria, interview in Arabic and English.

Although, several participants mentioned having to wait for health screening, for several months after arriving to Sweden. The main reason this was considered to be a problem was concern about the spread of infectious diseases. Several factors were mentioned by the participants as risk factors for the spread of infectious diseases and as reasons that the health screening should have been conducted earlier after arrival. These included the mode of travel to Sweden, but mainly that they lived at asylum accommodation centres together with people from different parts of the world, in small or shared rooms, with shared facilities such as bathroom, kitchen and dining hall. The participants did not mentioned any specific infectious disease, except for scabies\(^\text{11}\), which several were aware of had spread at the asylum accommodation centres. One participant said she had preferred infectious diseases screening before placement at the asylum accommodation centre.

*We expected health professionals to meet us, that they would conduct these tests before placing all these people together in one facility. There is a lot of people and many had scabies, many had other diseases. We come from many different countries, many from Somalia, from Eritrea, from Iraq, from Syria, from Afghanistan. It would have been better if they took these tests before placing these people together, because maybe someone carried an infectious disease. For example, one woman, she did have an infectious disease, and later on she was isolated but it took a long time before that happened.* P4. Woman, 27 years, Syria, interview in Arabic.

Unmet health needs during health screening
Even though many referred to the health screening as good and many had received help with several of their health problems, almost all participants had some remaining health problems that they had

\(^{11}\) See Glossary
not received any treatment for. A few participants had been told, during health screening, to make an appointment at another health care centre for their health problem, but had not managed to do so on their own. Some described being referred to specialised care, and then waited a long time for the appointment. This waiting time affected their wellbeing negatively. Some participants described that they had received medical advice, but did not consider these appropriate for their condition. A few participants said that their physical health problems had been explained as being caused by mental health problems or stress, but they had not received any help for it. This resulted in a feeling of not being listened to and many experienced it very difficult to receive appropriate treatment for their health problems.

_It feels like, in Sweden, there is no treatment, just pain relief medication._ P7. Woman, Syria, interview in Arabic.

Several mentioned that they had not received any results from the blood tests for infectious diseases that had been taken, which was considered confusing. Generally, results from blood tests taken during health screening are only communicated to a patient if they are positive and the patient needs treatment or follow-up, but very few of these participants knew about this. One participants reacted strongly to this, saying that it felt like this was important information about her health that she did not have access to.

_I don’t know why they want make check for blood for any disease, like person come new to Sweden, why they don't send to him or her, the result, at home. If the result negative or positive, he or she must know it. After I make the check, no call or result, nothing they send._ P11. Woman, 28 years, Palestine, interview in English.

**Different expectations on a health screening**

Many participants mentioned that the health screening was not what they had expected it to be. Many said “it was just blood samples and some talking”, when they had expected a health screening to involve physical examinations and sometimes other kinds of laboratory tests. One of the participants referred to the health screening as confusing, saying that he did not know what to expect and that the questions asked did not seem important to his health situation.

_They only took my blood test, and you know, I was expecting that they were also going to have the urine sample, but they didn't ask for urine sample, (...) in Afghanistan when they're
saying the medical check up so it was including everything and not only the blood. P10. Man, 28 years, Afghanistan, interview in English.

The interview did not include specifically which information they had received about the health screening before coming to the appointment, but a few participants mentioned that they had not realised that it was a screening appointment. In those cases, they were seeking health care for a specific condition and were referred to health screening instead. Most participants realised that the appointment was for a health screening, but did not know what this included.

The need for more information
All participants were asked about the information provided during health screening. The term information refers to information about the health care system in Sweden, about regulations regarding asylum seekers’ right to health care and how to contact health care. The overall understanding among the participants was that there was far from enough information provided during health screening for asylum seekers to be able to navigate in the health care system. Several participants highlighted this lack of knowledge with that they would not know what to do if they or someone else was in need of health care.

I don't know a lot of information like this, and no one can speak with me about this from like vårdcentral (health care centre) eller (or) something like this. I know they don't speak with people until they have uppehållstillstånd (residence permit), but it's problem, because maybe for one year eller (or) more, the person still without uppehållstillstånd (residence permit), for one year he still don't know any information for the health, for the care, for anything can happen with him eller (or) her. P11. Woman, 28 years, Palestine, interview in English and Swedish.

Most of the participants stated that they had received some information, but it was often limited to the phone number to the health care hotline, 1177, and the emergency phone number. Several participants also mentioned that they did not know how to use these phone numbers.

They give me 1177, this is a number and when I called them to book a date for my tooth, and they told me okey go to that place, I thought I make appointment. So when I go there, the told me no you didn't make any appointment, we don't know about you anything (...). We received no information, just this 1177. P9. Man, 41 years, Syria, interview in English and Arabic.
A few participants said that they had received satisfying information, but they either spoke English fluently, had no health problems or had family who had lived in Sweden for years. All of these except for one, pointed out that even if they themselves could manage with the information they had received, most other asylum seekers had a lack of knowledge and the information provided during health screening would not have been sufficient for them.

_For some people it can be bit difficult, to understand how things work (...). But for me, I read on the internet, I read how things work, but some people don't have that sort of access to things and find it difficult._ P6. Man, 28 years, Bangladesh, interview in English.

Several participants pointed out that the rules were often complicated and difficult to adjust to. One participant exemplified this with a problem that occurred when asylum seekers attempted to understand and follow the rules that they had heard about. This case regards a rule stating that the Migration Agency\(^\text{12}\) should pay everything above a certain amount, for asylum seekers buying medicines on prescription. This rule, and the procedures around it, were too complicated to understand and almost impossible to find reliable information about. According to this participant, it caused frustration among some of the asylum seekers, who had no one to turn to to receive correct information.

_For example, for the medicine, when they are paying, it is really complicated, (...) because I think for more than 400 the migration is paying, and in some cases they are not paying, nobody knows why. Because one time they say, if you are buying medicine from the pharmacy, if it is over 500 kronor (...) we will pay you, but there are some people in the camp they are complaining that they have bought about 800 kronor but the migration only pays about 300 or 250._ P10. Man, 28 years, Afghanistan, interview in English.

When asked about which information they would have liked to receive during health screening, few participants could suggest information they would have liked to receive themselves. But several participants pointed out knowledge gaps and unmet needs for information that they had identified among other asylum seekers. They mentioned specific topics which they considered it important to provide asylum seekers with information about, in order for them to be able to access health care and keep themselves healthy. These topics mainly regarded how to access the health care system and the regulations that applied to asylum seekers in health care, but also general health information.

\(^{12}\) See Glossary
about how to avoid spreading of infectious diseases and about child health. The participant behind
the following quote had already suggested for an organisation that they should arrange for
information sessions at the asylum accommodation centre, on the topics he mentions.

The important things about the health sector, for one hour or two hours, it would be very
interesting also for them, because (...) if they have any problem, they think that they have to
pay with their own money, so like a presentation if anybody can explain them, that which
kind of disease are free and which kind of health problems you need to pay with your own
money (...). It’s very important yeah, because they know nothing about the procedure and
what is the procedure, they know nothing. P10. Man, 28 years, Afghanistan, interview in
English.

Problems related to the accessibility of the health care system despite having
attended health screening
When the participants shared their experiences of the health screening, they rarely separated this
from experiences of other health care appointments. Rather, their experiences often regarded the
health care system as a whole. This shows that the differentiation between health screening and
other appointments is a differentiation made by the health care system and that the participants do
not perceive it the same way. As the health screening is connected to the entire health care system
through referrals to health care centres or specialised care, the researcher has included experiences
which regards the health care system as a whole.

The health care system is difficult to access
Almost all participants experienced the health care system in general as inaccessible. One important
barrier to receiving health care was that booking an appointment at a health care centre required
speaking Swedish, especially since the booking was made over telephone. In an attempt to
overcome this barrier, one of the participants went to the health care centre without an appointment.
There, he felt like he was disturbing the system, since he could not speak Swedish, he did not know
the rules and he had no appointment booked. He ended up sitting at the health care centre for hours,
before receiving an appointment.

Something that was a common source of frustration was the long waiting time for an appointment at
health care centres. Often, several weeks to a month passed between the first contact with the health
care centre and the appointment. For the participants who had experiences from emergency health
care and had to wait several hours in the emergency department, this was especially evident. One
participant, who had experiences in waiting a long time both for emergency health care and maternal health care, compared this to health care in her country of origin, where she could often see a doctor on the same day.

In Syria, if you need help, as soon as you say ouch, that you are in pain, you get to see the right person. P3. Woman, 44 years, Syria, interview in Arabic.

Several participants said that one of the main barriers to accessing health care was living at an asylum accommodation centre outside the city. There was not always staff present and these participants were concerned about what to do if anything happened, especially if anyone became ill at night.

A few practical barriers to accessing health care were travelling costs and finding the way to the health care centre. For some participants, health screening had been conducted by a mobile team at the asylum accommodation centre. These participants had all experienced being visited by the mobile team as positive, since this meant that they did not have to travel to the health care centre. One participant, as stated in the quote below, was relieved that she, her husband and their small children could go through health screening without travelling by bus to the health care centre.

I thought it was good that they came here, because it is difficult for us who have just arrived, we can not find our way anywhere, then we do not have to search, since it takes such a long time for us. P1. Woman, 30 years, Syria, interview in Arabic.

Relying on others to access health care
A few participants did not experience the health care system as difficult to access. In those cases, they knew people who had lived in Sweden for a long time or they did not have health problems. A connection to a person who spoke Swedish was mention by several participants as the only way of accessing the health care system, which highlights the participants’ reliance on others to help them access health care. For some participants, these Swedish connections were relatives, and for others, they were members of an organisation or for other reasons visiting the asylum accommodation centre.

From the doctor who I showed my hand to, the one who came here, I received no help at all, but there was another Swedish woman who came here and saw my hand, then
she called and made an appointment at the hospital. P2. Woman, 35 years, interview in Arabic.

The participants who lived at asylum accommodations centres often asked the staff to book appointments at the health care centre or dentist for them. This was a common strategy to gain access to the health care system through a connection with Swedish people, but it was not always a successful strategy. The participants perceived the staff members as kind, but very busy. Contacting health care was not included in the staff’s job. Due to lack of time or knowledge on how to contact health care, they could sometimes not provide any help with booking appointment. When this happened, the participants had no one else to turn to.

There are still many who show up at the reception asking for help with booking doctor’s appointments, and of course they try to help but sometimes they say, you have to come back later or come back tomorrow, (...) there is a need for someone who can help and book all these appointments. P9. Man, 41 years, Syria, interview in English and Arabic.

One participant shared the story of when her infant son became ill, at a time when the staff was not present, and the risks this meant for her son. She did not know any other way of contacting health care except for asking the staff for help and the closest pharmacy was a long busride away.

A while ago, my son got a high fever during the night and I had no medicines at home, so I borrowed a pill from the neighbour and gave him. For two full days he had red spots all over his body. Then, one of the staff members came back and he gave me these suppositories that got the fever down, and then it turned out that this pill I got from the neighbour was aspirin, and he is allergic to that. P2. Woman, 30 years, Syria, interview in Arabic.

Avoiding to seek health care
Several participants stated that the difficulties in accessing health care resulted in that they delayed seeking health care or avoided it altogether. One participant highlighted that it was the complicated procedures around the health care system that made him hesitate in seeking health care when he needed it. He referred specifically to the systems with different numbers used for identification in different governmental organisations.
There are different sorts of numbers and everything, so yeah, I as an outsider sometimes it feels ... sometimes I don't feel motivated enough to come. P6. Man, 26 years, Bangladesh, interview in English.

Some participants had given up on seeking health care, after previously being in contact with the health care system. They had all been disappointed by previous health care encounters, often by not being listened to or by not receiving any effective treatment. The participant in the quote below said that several of her friends at the asylum accommodation centre had similar experiences. She explained that this often resulted in having to seek health care later on, as the health problems got worse.

We already know what kind if treatment we will receive, so now we keep it at home, we might as well take it here instead of seeking health care. But after a few days, you have to go anyway. P7. Woman, Syria, interview in Arabic.

The participants described different solutions for treating themselves at home, like medicines that could be bought at a pharmacy without prescription, which were often recommended when seeking health care, or avoiding disease so they did not have to seek health care, by eating healthy. Some used herbs for treating their health problems, or asked friends for medical advice. One of the participants described a situation where she, rather than seeking dental care, chose to have her friends at the asylum accommodation centre punctuate an abscess in her mouth.

Discussion

This study explored the experiences of asylum seekers regarding health screening for migrants. The findings showed that asylum seekers’ experiences of health screening were varied and complex. The health screening was considered important and useful, in terms of identifying infectious diseases, and health professionals were considered nice. Yet, there was a general disappointment regarding not having received help with health problems and not having received useful information to navigate in the health care system. The problems in accessing health care, leading to avoiding to seek care or relying on help from others, overshadowed the positive aspects of the health care experiences. In this section, these findings will be discussed through the framework of health literate organisations. In the end of this section, in Table 3, suggestions for improvement based on the discussion are presented.
One main finding, which affected all other findings as well as the way the researcher understood asylum seekers’ experiences of health screening, was that the participants did not see health screening as a separate appointment, but rather incorporated it into their other health care experiences and viewed the health care system as a whole. This made it more complex to investigate specifically the experience of the health screening, than initially expected. But mainly, it highlighted the role health screening should have within the health care system, to introduce and connect asylum seekers to the health care system. This is also one of the stated purposes of health screening (30, 31). The findings indicate that there are improvements needed for health screening to fulfil this role, as has been previously argued in the quantitative study by Pacheco et al (38).

Previous studies have largely focused on what health care professionals or experts in the field have to say about health care or health screening for migrants. This study focuses on the experiences of asylum seekers, thus filling a gap in research. Furthermore, the previous studies on health screening from the migrants’ perspective, have with few exceptions included migrants with residence permit. The participants in this study are asylum seekers, who are considered a more vulnerable group (9-11, 15, 16) and have limited legal access to health care compared to migrants with residence permit (21, 22). This means that they are likely to have a different perspective on health screening.

**Health screening could be an opportunity**

Under the right circumstances, health screening is a good opportunity to provide solutions for several of the problems and barriers identified in this study. It is a unique opportunity to connect asylum seekers with the health care system, by providing information about regulations regarding right to health care and the health care system, as well as assisting with referrals or making necessary appointments. Compared to other health care appointments, health screening offers plenty of time for each patient and the possibility of addressing all health problems. Generally, health professionals working with health screenings are knowledgeable of the Swedish health care system and other relevant organisations. There are aspects of health screening that were appreciated by the participants in this study, including that the health professionals were considered nice and that the screening for infectious diseases was considered useful. Therefore, health screening has a potential to fulfil its role in informing and connecting asylum seekers with the health care system.

**Meeting the expectations on health screening**

Participants both in the present study and in previous studies consistently expected other things from health screening. Previous studies on health screening (34, 36-39) all identified disappointment due to unmet expectations of different physical examinations, laboratory tests or
medical treatments, similar to what was shown in this study. Some participants in this study and in the previous studies alike, related this to that they had not received any or limited information before the health screening, regarding what the purpose and content of health screening is and how it is conducted. Participants in previous studies also did not know that health screening was voluntary and could not have made an informed decision on whether to participate (34, 36-39). This was not investigated in the present study, but it is likely that the participants were not aware of that health screening is voluntary, considering the similarities to previous research in expectations and lack of information. In the framework of health literate organisations, providing patients with information and confirm understanding, as well as providing easy access to information, is essential (Table 1). Considering this, measures must be taken to inform asylum seekers about the health screening before they can take a decision on whether to participate or not, and this needs to be done in a language that the individual understands, using a way of communication that is appropriate.

Many participants, in this as well as in previous studies, expected to receive treatment for their health problems (36-39). This is of course a reasonable expectations from a health care appointment. Medical advice or treatment should be provided according to the objectives of a health screening (30, 31). Still, many experienced unmet health needs after health screening, just as in previous research (35-39). Most likely, a combination of several factors led to this experience. The participants in this study, as in the other studies, stated that the health care in Sweden differed from in their countries of origin, in terms of choice of medical treatment, the view on self-care, health care professionals’ responsibilities, and waiting times, which can be associated with unmet expectations. A the time, the Swedish health care system was in a turbulent situation, with lack of staff and increased waiting times. This was frequently reported in media and caused strong reactions among the public. Reacting to this with disappointment would not be unique for asylum seekers, but common at the time among Swedes and migrants alike.

Several participants were under the impression that the main purpose with health screening was infectious diseases control, which is similar to previous studies (36-39). According to the objective, infectious disease control and treatment of other health problems, are of equal importance (30, 31), but the participant did not experience this from the health screening. A health literate organisation should clearly communicate which rights a patient has, what they can expect from the health care system and confirm understanding as well as provide easy access to services (Table 1). Regarding the unmet needs, a combination of appropriately communicated information, to avoid misunderstandings, and improved follow-up of health problems during health screening, could improve asylum seekers experience of the health screening and of the health care in general.
Knowledge is power
Health care systems are increasingly complex to understand, for migrants and citizens alike. Health information today comes from many different sources and it is often difficult to assess if the information is reliable or not (41). For asylum seekers, large amounts of complicated information about regulations and rights were communicated during relatively short appointments in government institutions. Concerns have been raised if this causes an overload of information, making it difficult to remember (35). At the time of the study, other than health screening there was no organised way for asylum seekers to receive information about the regulations regarding their right to health care or about contacting health care, except for sporadic information sessions initiated by different organisations. The participants in this study had received very limited information, which was evident considering many did not know how to contact health care if needed. Many expressed a need for more information regarding health care, for themselves and others. Previous studies similarly show a lack of information during health screening and a need for more information (36-39). In this study, the participants were also asked to share suggestions on which information they requested, which had not been done in previous studies. The gaps in knowledge that the participants pointed out were general information on health care that should have been communicated during health screening, according to the objectives (30, 31) as well as information on infectious diseases that were important for those living at asylum accommodation centres. In practice, since health screening had not succeed in delivering this information, asylum seekers were left to ask friends or family for advice, treat their health problems at home or find ad hoc solutions like asking the staff at the asylum accommodation centre.

According to this studies framework, providing appropriate information in an appropriate way is an essential aspect for an organisation to be health literate, and reduce the demands enough for the patient and organisation to meet (43, 44). Examples of this are providing easy access to health information, including various forms of material, confirming understanding, using health literacy skills in communication without stigmatising individuals with lower health literacy and communication what kind of health care the person has access to, as seen in attributes 5-8 and 10 (Table 1). Clearly, the way health screenings were conducted were not in accordance with the attributes of a health literate organisation. Previous studies with nurses conducting health screening, show that lack of time and organisational problems make it difficult to communicate information in a proper way (35). Using other ways of communicating health information is one way of improving knowledge. In one study, groups of asylum seekers originating from different countries showed very different preferences in how they wanted to receive information, for example regarding...
internet use or written material (39). In a Swedish intervention study, health information was provided to groups at one separate occasion, with positive results (40). This was also a suggestion from one of the participants in the study. The researchers’ experience from health screening and conducting health information sessions was that health information was received better in group sessions, than during health screening.

Providing asylum seekers with appropriate information would not solve all problems regarding health screening and the health care system. However, asylum seekers ask for more health information and navigating in the health care system requires knowledge, as seen in this study as well as in previous research (18, 19, 24, 27, 38, 40). Knowledge is power - it is impossible for asylum seekers to fulfil their right to health, if they are not aware of their rights or how to access health care. Health screening failed in communicating this to asylum seekers, leading to the conclusion that providing the health information needs to be organised in another way.

**Increasing asylum seekers’ access to the health care system**

Health care in Sweden is difficult for asylum seekers to access, which is evident from the participants’ experiences. It is also well documented in previous research from Sweden (24, 28, 36-39) and has been brought up in several national (8, 27, 33) and international reports (9, 10, 18).

Apart from improved information, there are several aspects that need to be addressed to increase asylum seekers access to health care. The participants in this study expressed this by identifying some of the barriers they experiences to accessing health care and by describing the strategies they used to overcome these barriers. This was described as the cause of strong negative emotions and contributed largely to the notion on disappointment in the health care system in this study.

The reasons why asylum seekers experience the health care system as inaccessible are related to their situation, as well as the complicated procedures of the health care system. Asylum seekers’ unique situation involves that they have limited legal access to health care, do not speak enough Swedish, lack a social network, and are can have problems to afford the travels to health care or medicines. These aspects has also been seen in previous studies and reports (9, 15-19, 24, 27). The reasons mentioned in this study regarding the health care system includes that it is complicated to make an appointment over the phone in Swedish and that it is difficult to understand where to turn for one’s health problem, as was also shown in another study (38). Since the law regarding their right to health care both limits their right and at the same time is unclear and open for interpretation (21-23), there is a clear risk that asylum seekers can access different levels of care, depending on which health care professional they meet. These barriers all interact, creating the experience that the
Swedish health care system is inaccessible for asylum seekers. That asylum seekers rely on Swedish people around them to access health care is a relatively new findings, which is an strategy to overcome these barriers.

A finding in this study, which has not been as prominent in other studies, can be seen both as a consequence of the accessibility problems and a strategy for regaining power of the the situation and health. Asylum seekers avoided or delayed seeking health care and attempted to treat health problems at home, due to having experienced health care as complicated or being discontent with previous health care appointments. This may result in delayed treatment for serious health problems, with higher risks for the patient and higher costs for the health care system. Therefore, it is in the interest of both parties to increase the access to health care for asylum seekers.

A key attribute of a health literate organisation is that it “provides easy access to health information and services and navigation assistance”, as seen in attribute number 7 in the framework (Table 1). Seen through the experience of the asylum seekers, the Swedish health care system does not live up to this. Furthermore, the health screening for migrants that is supposed to increase the access to the health care system by referral and information, does not succeed in doing so. This was also the conclusion of another study, including migrants who had been granted a residence permit after seeking asylum (38). In increasing access, navigation assistance is of importance, and the participants themselves also request someone to help them make appointments. Several of the participants in this study have been asked, during health screening, to make an appointment at another health care centre themselves, but have not managed to do so. In these cases, the problem had been easily solved by the nurse ensuring that the person had the knowledge needed to make the appointment, or assisting the person in making it. Although, when asylum seekers need to access health care at other times, navigation assistance is more complicated. A few suggestions for improvement regarding access are presented in Table 3. However, one of the most important problems, that asylum seekers do not have legal access to all health care, remains even if appropriate information and navigation assistance is realised.

**Improving health screening**

This study has shown several problems in health screening that need to be addressed before health screening can fulfil the role it was intended to have. Some suggestions for improvement, based on the findings in this study with considerations to previous research and the framework for the study, are presented in Table 3. Another important aspect is further research, to investigate the reasons for the low attendance rate, which can lead to further improvements.
Table 3. Suggestions for improving health screening and to increasing asylum seekers access to health care

<table>
<thead>
<tr>
<th>Suggestion</th>
<th>Why and how?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health screenings sooner after arrival to Sweden*</td>
<td>• Decreases the risk of infectious diseases spreading</td>
</tr>
<tr>
<td></td>
<td>• Health needs are identified and treated sooner</td>
</tr>
<tr>
<td></td>
<td>• Reduce the need for asylum seekers to try to access health care without having received health information</td>
</tr>
<tr>
<td></td>
<td>*Requires that other improvements are made to health screening.</td>
</tr>
<tr>
<td>Mobile teams for health screening*</td>
<td>• Reduces barriers to attend health screening</td>
</tr>
<tr>
<td></td>
<td>• Believed to increase attendance at health screening</td>
</tr>
<tr>
<td></td>
<td>• Presence at asylum accommodation centres increases chance for asylum seekers to contact health care, for health problems or advice</td>
</tr>
<tr>
<td></td>
<td>• Provides an opportunity to inform asylum seekers about the purpose and content of health screening</td>
</tr>
<tr>
<td></td>
<td>*Requires that other improvements are made to health screening.</td>
</tr>
<tr>
<td>Improve the way health information is communicated</td>
<td>• Investigate appropriate ways of communicating health information, by involving asylum seekers in the design, implementation and evaluation.</td>
</tr>
<tr>
<td></td>
<td>• Offer several ways of accessing health information, such as group information sessions, a website, short films or written material.</td>
</tr>
<tr>
<td>Navigation assistance</td>
<td>• Provide assistance to asylum seekers to navigate in health care and make appointments</td>
</tr>
<tr>
<td></td>
<td>• Investigate appropriate ways of navigation assistance, by involving asylum seekers in the design, implementation and evaluation.</td>
</tr>
<tr>
<td>Make the health care system more accessible</td>
<td>• Provide solutions to make health care appointments in several languages, for example using telephone interpreters or technical solutions</td>
</tr>
<tr>
<td></td>
<td>• Free public transport for health care</td>
</tr>
</tbody>
</table>

One important aspect regarding all suggestions for improvements (Table 3), is taking asylum seekers’ views into consideration. A health literate organisation includes the population in planning, implementing and evaluating both services and information (Table 1), making them active participants in developing a health screening suited to their unique needs. Studies like the current study is one way of identifying asylum seekers’ views. Other ways that health care organisations
can use are focus group discussions, which can be used for designing, implementing and evaluations health information or interventions, or short questionnaires, used to evaluate the services provided.

**Methodological considerations**

The criteria to ensure trustworthiness in qualitative studies by Shenton (52), which are in turn based on the criteria developed by Guba (53), was followed in this study. The following areas were addressed to ensure that the requirements for trustworthiness were met; credibility, transferability, dependability and conformability. For a complete list on all measures taken to achieve trustworthiness in this study for each of these areas, see *Annex 4*.

**Credibility**

Whether the findings of a study are considered credible, or as true to reality as possible, depends on several factors (52). In this study, a significant strength is that several measures were taken to achieve credibility. The researcher had previous knowledge of the health care system organising health screening and from visiting the asylum accommodation centres, and could therefore organise the field work according to this knowledge. Using a qualitative approach for this under-researched area was appropriate (46, 47) and provided a significant contribution to the research field. Consistency in the research process was provided by that the researcher conducted and analysed all interviews. Several measures were taken to ensure that participants felt comfortable and relaxed during interviews \(^\text{13}\), which should increase openness and sincerity in the interviews (52).

Cross-language and cross-cultural research, as well as the use of interpreters, were significant limitations in this study. This posed some challenges for the researcher, especially in understanding the nuances, expressions and references participants made during interviews. This was addressed by selecting and informing interpreters and validating the translation \(^\text{14}\), which reduced but did not remove the risk of misinterpretations.

The researcher is a student researcher and not an experienced researcher, which is of course a limitation. Although, the research process was continuously discussed with several experienced researchers throughout the study \(^\text{15}\). A limitation is that it was not possible, due to restrictions in the funding for interpretation, to return the findings to the participants for feedback on whether the

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\(^{13}\) See Data collection

\(^{14}\) See Data collection

\(^{15}\) See Data analysis
researcher had understood correctly, or to conduct triangulation with different data sources (52). Although, participants from different backgrounds were purposively recruited and had similar experiences, which contributed to a rich data set and the possibility of triangulation via data sources (52). Additionally, the findings in this study are similar to the findings of previous studies, which indicates that these experiences are common among asylum seekers in Sweden.

**Transferability**

The findings of a qualitative study can not be generalised, as qualitative research is context-specific. Transferability refers to that the researcher provides enough information about the context and field work for the reader to assess whether the findings can be applied to other settings (52). In this study, the researcher has attempted to provide as much relevant information as possible about the context, field work, participants and methods used16.

Within Sweden, health screening, as well as the larger health care organisation and asylum seekers access to health care, is organised in slightly different ways between the counties, but they follow the same guidelines for purpose and content of health screening. It is therefore possible that the findings in this study can be transferred to other settings within Sweden, but considerations must be made to how health screening is organised locally. This is supported by the similarities between this study and previous research. Transferring these findings to other European countries may or may not be possible, depending, among other aspects, on the regulations for health screening and access to health care for asylum seekers in each country.

**Dependability**

Dependability refers to enabling a future researcher to, as far as possible, repeat the study. This requires detailed description of the method used. In qualitative research, as compared to quantitative research, this does not necessarily mean reaching the same conclusions, since contexts change (52). In this study, efforts have been made to describe every step of the research process in detail17, as well as the context18. Additionally, an interview guide was used for the semi-structured interviews (Annex 2) and the data was analysed with qualitative content analysis by Graneheim and Lundman19 (47), which provides quite detailed explanation of every step of the analysis process.

**Conformability**

16 See Research setting, Data collection and Findings
17 See Methodology
18 See Research setting
19 See Data analysis
In qualitative research, each researcher brings a unique perspective to the study. Even so, the researcher must strive towards ensuring that the findings are a result of the participants’ experiences, rather than deriving from the researcher’s pre-existing ideas (52). Considering the researcher’s previous experience in working with health screening for migrants, her pre-existing understandings posed a risk for interpreting the data in certain ways. Steps taken to ensure this in the current study were following a established analysis method with a manifest approach\(^{20}\), providing a detailed methodological description\(^{21}\) and including quotes to support the statements made\(^{22}\). But, most importantly, the researcher practiced reflexivity throughout the research process\(^{23}\), constantly questioning assumptions and pre-understandings and changing perspectives when discovering that certain pre-existing understandings did not agree with what the participants experienced.

**Other strengths and limitations**

One of the most significant limitations to this study was that the researcher was only able to arrange for translation to a few of the languages common among asylum seekers. This was likely to be the reason that no participants originated from Africa, even though many asylum seekers in Sweden originate from Eritrea and Somalia. During recruitment, attempts were made to include participants from African countries, but for practical reasons this did not succeed.

Another possible limitation was that at the time of the interview, about a year had passed since health screening was conducted for several of the participants. This might have resulted in recall bias (46), since it might be difficult to remember details a long time afterwards. It might also have contributed to that the participants’ different health care experiences formed into one general understanding of the health care system. However, health screening might include follow-up visits and referrals, affecting the experience of the health screening. These important aspects would have been lost if data collection was conducted sooner after health screening.

**Conclusion**

Asylum seekers considered health screening to be appropriate for infectious disease control, but it did not meet their expectations and health problems were often left without treatment. Asylum

\(^{20}\) See Data analysis  
\(^{21}\) See Methods  
\(^{22}\) See Findings  
\(^{23}\) See Reflexivity
Seekers experienced problems in accessing health care. Health screening is a missed opportunity to provide asylum seekers with sufficient information to navigate in the health care system. With improvements regarding the health literacy of the health care organisation, health screening is an opportunity to connect asylum seekers with the Swedish health care system and to improve the access to health care for asylum seekers.

**Further research**

There is a need for more quantitative and qualitative research on the topic of health screening and health care for migrants. It is essential that the voices of asylum seekers and others migrant groups are represented in this research. One of the main problems identified in this study, that health care is experienced as inaccessible for asylum seekers, needs to be addressed in future research to identify solutions. To gain knowledge about why asylum seekers are attending health screening in such low numbers, qualitative research focusing on asylum seekers who have not, for whatever reason, attended health screening, needs to be conducted.

Several of the suggestions for improvement identified in this study already have support from previous research as well as from official sources. Therefore, implementing these improvements and conducting intervention studies, to investigate whether they are indeed effective in increasing asylum seekers’ access to health care, would be an appropriate next step.
References


Copenhagen: WHO Regional Office for Europe; 2015 (Health Evidence Network synthesis report 44).


40. Ekblad S, Linander A, Asplund M. An exploration of the connection between two meaning perspectives: an evidence-based approach to health information delivery to vulnerable groups of


Annex 1. Informed consent form.

Informed consent form

This informed consent form is for potential participants in the study “Migrants’ experience of health screening”. With this consent form we wish to provide you with information on the study and invite you to participate.

The study is conducted by Elin Lampa, Registered Nurse employed at Cosmos, asylum and integration health care centre, and master student in international health at Uppsala University.

Purpose of the study

The purpose of the study is to investigate how migrants experience the health screening which is offered after arrival to Sweden. Understanding how you as a patient experience the health screening is important to us, since the health screening should be a good experience.

The results will presented at Uppsala University and at Cosmos, asylum and integration health care centre, and will be used to improve the quality of the health screening.

Your participation

Your participation will consist of an interview with Elin and, if you need it, an interpreter. The interview will be on the topic of your experience of the health screening, it will last approximately one hour and it will be audio recorded.

Who the participants in the study are, will not be known to anyone except the researcher and the interpreter. You will not be identified by name in the study.

Your participation is entirely voluntary. You may change your mind and quit your participation at any time during the study. Whether you choose to participate or not will have no consequences for your health care, your case at Migrationsverket, your accommodation or any other matters.

Contact

If you have any questions about the study, please Elin Lampa.

If you can speak Swedish or English, call 018-611 18 06

Or else, email me on your own language, and I will contact you elin.lampa@lul.se eller eliningelampa@gmail.com
Certificate of consent

I consent to participate in the study “Migrants’ experience of health screening”. My participation means participating in an interview. I have been informed that my participation is completely voluntary and that I can chose to end my participation at any time during the study.

I have read the information, or it has been read to me. I have had the opportunity to ask questions about it and they have been answered to my satisfaction. I consent voluntarily to be a participant in this study.

Name of Participant ________________________________
Signature of Participant ________________________________
Date ________________________________ Day/month/year

Statement by the researcher/person taking consent

I have accurately read out the information sheet to the potential participant, and to the best of my ability made sure that the participant understands that the agreeing means participation in an interview about their experience of health screening. I confirm that the participant was given an opportunity to ask questions about the study, and all the questions asked by the participant have been answered correctly and to the best of my ability. I confirm that the consent has been given freely and voluntarily.

Name of Researcher/person taking the consent ________________________________
Signature of Researcher/person taking the consent ________________________________
Date ________________________________ Day/month/year

For any questions, please contact:

Elin Lampa
018 611 18 06
076 248 34 56
eliningelampa@gmail.com
elin.lampa@lul.se
Interview guide

Thank the participant for their interest in participating with their experiences to the study.

Presentation of the researcher and the interpreter.

Presentation of the aim of the study, why the study is conducted and how the results will be used.

Explain how the interview will be conducted.

Explain that participation is entirely voluntary and can be ended at any time, without any consequences.

Explain how the recorded material and the transcripts will be handled and kept.

Ask the participant to (if possible) read and sign the informed consent form. If not: researcher and interpreter read the information out loud and ask for oral consent.

Background information:

Gender, country of origin, age.

Start with an open question:

Tell me about your experience of the health screening.

Depending on which direction the interview takes, following questions can lead the interview back to the topic:

Which expectations did you have on the health screening before you went there? How well did these fit with your experience of the health screening?

What was positive? What was negative?

If you had any health problem, how did you experience the treatment of these?

If the information does not come up (i.e. information about right to health care as an asylum seeker etc):

What kind of information did you receive about health care and how to seek health care? What kind of information did you receive about your rights to health care?

Annex 2. Interview guide (cont.)
How did you experience this information? What was important? What was missing?

General questions:

Would you recommend other people to attend this health screening?

Can you suggest any improvements?

The answers from the participant will be followed by follow-up questions to encourage the participant to share more and for clarifications. Prompts and short summaries will be used throughout the interview.

When the participants does not have anything more to share, the interview is ended with the researcher providing a short summary to see if she has understood the participant correctly, and offer the participant to add more or clarify any misunderstandings. Thereafter, the researcher thanks the participants and the interview ends.
### Annex 3. Table of participants

<table>
<thead>
<tr>
<th>Nr</th>
<th>Country of origin</th>
<th>Gender</th>
<th>Age</th>
<th>Interview situation</th>
<th>Language of interview</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Syria</td>
<td>Woman</td>
<td>30 years</td>
<td>In an office at an asylum accommodation centre.</td>
<td>Interpretation to Arabic</td>
</tr>
<tr>
<td>2</td>
<td>?</td>
<td>Woman</td>
<td>35 years</td>
<td>In an office at an asylum accommodation centre.</td>
<td>Interpretation to Arabic</td>
</tr>
<tr>
<td>3</td>
<td>Palestinian, lived in Syria</td>
<td>Woman</td>
<td>44 years</td>
<td>In private room at asylum accommodation centre. Friends join in the end of the interview.</td>
<td>Interpretation to Arabic</td>
</tr>
<tr>
<td>4</td>
<td>Syria</td>
<td>Woman</td>
<td>27 years</td>
<td>In private room at asylum accommodation centre. Husband joins the in the end of the interview.</td>
<td>Interpretation to Arabic</td>
</tr>
<tr>
<td>5</td>
<td>Palestine</td>
<td>Man</td>
<td>28 years</td>
<td>At the health care centre.</td>
<td>Interpretation to Arabic</td>
</tr>
<tr>
<td>6</td>
<td>Bangladesh</td>
<td>Man</td>
<td>26 years</td>
<td>At the health care centre.</td>
<td>English</td>
</tr>
<tr>
<td>7</td>
<td>Syria</td>
<td>Woman</td>
<td>Unclear, 25-35 years</td>
<td>In an office at an asylum accommodation centre. A friend is sitting in at the interview at the participant’s request.</td>
<td>Interpretation to Arabic</td>
</tr>
<tr>
<td>8</td>
<td>Syria</td>
<td>Man</td>
<td>37 years</td>
<td>In an office at an asylum accommodation centre.</td>
<td>Interpretation to Arabic</td>
</tr>
<tr>
<td>9</td>
<td>Syria</td>
<td>Man</td>
<td>41 years</td>
<td>In an office at an asylum accommodation centre.</td>
<td>Mix between English and interpretation to Arabic</td>
</tr>
<tr>
<td>10</td>
<td>Afghanistan</td>
<td>Man</td>
<td>28 years</td>
<td>At the health care centre.</td>
<td>English</td>
</tr>
<tr>
<td>11</td>
<td>Palestine</td>
<td>Woman</td>
<td>28 years</td>
<td>At the health care centre.</td>
<td>English and some Swedish</td>
</tr>
</tbody>
</table>
# Annex 4. Measures taken to achieve trustworthiness

<table>
<thead>
<tr>
<th>Criteria*</th>
<th>Definition and requirements*</th>
<th>Measures taken to achieve</th>
</tr>
</thead>
</table>
| **Credibility**   | Aims to present a picture of the phenomena investigated that is as true to reality as possible. Assessed by how several factors in the study are addressed. | - Appropriate research design for the topic  
- The researcher had previous knowledge of the field and topic from working with health screenings and studying the topic  
- Purposive sampling of participants with different backgrounds  
- Interviews were conducted according to participants’ preferences  
- Purposive selection of interpreters, and translation validation  
- The research process was discussed with others throughout the study  
- The researcher collected, transcribed and analysed the data, providing consistency  
- The researcher’s role was reflected on throughout the study  
- Findings are similar to previous studies |
| **Transferability**| Transferability refers to that the researcher provides enough information about the context and fieldwork for the reader to judge whether the findings can be applied to other settings or contexts. | - Aimed to provide rich and relevant information about the context of the study  
- Aimed to provide rich and relevant information about the circumstances of the fieldwork  
- Aimed to provide rich and relevant information about the participants, recruitment and data collection |
| **Dependability** | Refers to enabling a future researcher to, as far as possible, repeat the study. This requires detailed description of the method. In qualitative research this does not necessarily mean reaching the same conclusions, since the context might have changed. | - Detailed description of how the study was conducted, in every step  
- Followed an interview guide for the semi-structured interviews  
- Followed qualitative content analysis by Graneheim and Lundman (39), with a detailed description how this was used in analysis |
| **Conformability** | Refers to steps taken by the researcher to show that the findings emerged from the data, and not from the researcher’s pre-existing ideas. | - Practiced reflexivity - identifying and stating own predispositions and reflecting upon them throughout the process  
- Detailed methodological description in all steps |

* Source (52)